		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040808

Facility Name: Roosevelt Square-Murphysboro

Address: 1501 Shoemaker Drive (Number) Murphysboro (City) 62966 (Zip Code)

County: Jackson

Telephone Number: (618) 684-2693 **Fax #** ( )

IDPA ID Number: 611278144001

Date of Initial License for Current Owners: 05/01/95

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[X]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Steve McGrath **Telephone Number:** (502) 394-2275

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Steven B. Mowery
(Title) Vice President of Reimbursement

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	76	Intermediate/DD	76	27,740	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,740	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	21,359			21,359	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,359			21,359	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.00%

D. How many bed-hold days during this year were paid by Public Aid?
82 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	82,484	9,394	5,898	97,776	99	97,875		97,875			1
2	Food Purchase		122,940		122,940	80	123,020	(46)	122,974			2
3	Housekeeping	54,819	6,775		61,594		61,594		61,594			3
4	Laundry	70,497	11,414		81,911	327	82,238		82,238			4
5	Heat and Other Utilities			55,241	55,241		55,241	472	55,713			5
6	Maintenance	16,561	24,177	15,801	56,539	2,180	58,719	3,698	62,417			6
7	Other (specify):*											7
8	**TOTAL General Services**	224,361	174,700	76,940	476,001	2,686	478,687	4,124	482,811			8
	B. Health Care and Programs											
9	Medical Director					19,200	19,200		19,200			9
10	Nursing and Medical Records	923,909	27,581	146,435	1,097,925	40,330	1,138,255		1,138,255			10
10a	Therapy		148	21,840	21,988	396	22,384		22,384			10a
11	Activities	26,845	766		27,611	2,168	29,779		29,779			11
12	Social Services	29,322			29,322		29,322		29,322			12
13	Nurse Aide Training	(582)			(582)	13,229	12,647		12,647			13
14	Program Transportation											14
15	Other (specify):* **Day Program**			729,097	729,097		729,097	(729,097)				15
16	**TOTAL Health Care and Programs**	979,494	28,495	897,372	1,905,361	75,323	1,980,684	(729,097)	1,251,587			16
	C. General Administration											
17	Administrative	55,186			55,186		55,186		55,186			17
18	Directors Fees							1,487	1,487			18
19	Professional Services			15,622	15,622	(8,507)	7,115	27,168	34,283			19
20	Dues, Fees, Subscriptions & Promotions			11,157	11,157	6,816	17,973	(225)	17,748			20
21	Clerical & General Office Expenses	42,660	9,846	91,527	144,033	(72,505)	71,528	173,938	245,466			21
22	Employee Benefits & Payroll Taxes			221,190	221,190		221,190	13,271	234,461			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,569	7,569	(3,673)	3,896	9,720	13,616			24
25	Other Admin. Staff Transportation			836	836		836		836			25
26	Insurance-Prop.Liab.Malpractice			33,597	33,597		33,597	56	33,653			26
27	Other (specify):*											27
28	**TOTAL General Administration**	97,846	9,846	381,498	489,190	(77,869)	411,321	225,415	636,736			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,301,701	213,041	1,355,810	2,870,552	140	2,870,692	(499,558)	2,371,134			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Roosevelt Square-Murphysboro #0040808 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			54,809	54,809		54,809	9,072	63,881			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			39,742	39,742		39,742	(6,435)	33,307			33
34	Rent-Facility & Grounds							5,474	5,474			34
35	Rent-Equipment & Vehicles			22,374	22,374	(140)	22,234	1,664	23,898			35
36	Other (specify):*											36
37	**TOTAL Ownership**			116,925	116,925	(140)	116,785	9,775	126,560			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			153,982	153,982		153,982		153,982			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			153,982	153,982		153,982		153,982			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,301,701	213,041	1,626,717	3,141,459		3,141,459	(489,783)	2,651,676			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$ (729,097)	15	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(46)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(277)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(650)	19		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(225)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Credits, RE Tax, Veh Lease	(16,215)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (746,510)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	256,727		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 256,727		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (489,783)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Roosevelt Square-Murphysboro

ID# 0040808

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6	Credits taken in prior years	3,503	24	6
7	Credits taken in prior years	66	19	7
8				8
9	Real Estate Tax Over-Accrual	(9,539)	33	9
10	Lease Exp. for more than one vehicle	(9,425)	35	10
11	Home Office PR Allocation	(820)	20	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(16,215)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Roosevelt Square-Murphysboro **#** 0040808 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(46)	0	0	0	0	0	0	0	0	0	0	(46)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	472	0	0	0	0	0	0	0	0	0	472	5
6	Maintenance	0	3,698	0	0	0	0	0	0	0	0	0	3,698	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(46)	4,170	0	0	0	0	0	0	0	0	0	4,124	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(729,097)	0	0	0	0	0	0	0	0	0	0	(729,097)	15
16	**TOTAL Health Care and Programs**	(729,097)	0	0	0	0	0	0	0	0	0	0	(729,097)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	1,487	0	0	0	0	0	0	0	0	0	1,487	18
19	Professional Services	(584)	27,752	0	0	0	0	0	0	0	0	0	27,168	19
20	Fees, Subscriptions & Promotions	(1,045)	820	0	0	0	0	0	0	0	0	0	(225)	20
21	Clerical & General Office Expenses	0	173,938	0	0	0	0	0	0	0	0	0	173,938	21
22	Employee Benefits & Payroll Taxes	0	13,271	0	0	0	0	0	0	0	0	0	13,271	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	3,503	6,217	0	0	0	0	0	0	0	0	0	9,720	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	56	0	0	0	0	0	0	0	0	0	56	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	1,874	223,541	0	0	0	0	0	0	0	0	0	225,415	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(727,269)	227,711	0	0	0	0	0	0	0	0	0	(499,558)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Roosevelt Square-Murphysboro **#** 0040808 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(277)	9,349	0	0	0	0	0	0	0	0	0	9,072	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(9,539)	3,104	0	0	0	0	0	0	0	0	0	(6,435)	33
34	Rent-Facility & Grounds	0	5,474	0	0	0	0	0	0	0	0	0	5,474	34
35	Rent-Equipment & Vehicles	(9,425)	11,089	0	0	0	0	0	0	0	0	0	1,664	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(19,241)	29,016	0	0	0	0	0	0	0	0	0	9,775	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(746,510)	256,727	0	0	0	0	0	0	0	0	0	(489,783)	45

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ResCare, Inc.	100	ICF/DD Group Homes & Nursing Home Only				
(Owns 100% of ResCare Illinois, Inc.)		(Non-Residential and Non-Health Omitted)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Admin Salaries & Services	$	ResCare, Inc.	100.00%	$ 173,938	$ 173,938	1
2	V	22	Payroll Taxes & Benefits		ResCare, Inc.	100.00%	13,271	13,271	2
3	V	24	Travel & Lodging		ResCare, Inc.	100.00%	6,217	6,217	3
4	V	30	Depreciation		ResCare, Inc.	100.00%	9,349	9,349	4
5	V	6	Maintenance		ResCare, Inc.	100.00%	3,698	3,698	5
6	V	5	Utilities		ResCare, Inc.	100.00%	472	472	6
7	V	26	Insurance		ResCare, Inc.	100.00%	56	56	7
8	V	34	Building Lease		ResCare, Inc.	100.00%	5,474	5,474	8
9	V	35	Equipment Lease		ResCare, Inc.	100.00%	11,089	11,089	9
10	V	18	Directors Fees		ResCare, Inc.	100.00%	1,487	1,487	10
11	V	20	Public Relations		ResCare, Inc.	100.00%	820	820	11
12	V	33	Taxes		ResCare, Inc.	100.00%	3,104	3,104	12
13	V	19	Professional Services		ResCare, Inc.	100.00%	27,752	27,752	13
14	Total			$			$ 256,727	$ * 256,727	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	NOT APPLICABLE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ResCare, Inc.
Street Address: 10140 Linn Station Rd.
City / State / Zip Code: Louisville, KY 40223
Phone Number: (502) 394-2100
Fax Number: (502) 394-2353

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Admin Salaries & Services	Days	2,032,280		$ 14,483,187	$ 14,483,187	24,407	$ 173,938	1
2	22	Payroll Taxes & Benefits	Days	2,032,280		967,476		27,877	13,271	2
3	24	Travel & Lodging	Days	2,032,280		345,754		36,542	6,217	3
4	30	Depreciation	Days	2,032,280		873,322		21,756	9,349	4
5	6	Maintenance	Days	2,032,280		349,724		21,489	3,698	5
6	5	Utilities	Days	2,032,280		39,806		24,098	472	6
7	26	Insurance	Days	2,032,280		4,565		24,930	56	7
8	34	Building Lease	Days	2,032,280		482,486		23,057	5,474	8
9	35	Equipment Lease	Days	2,032,280		1,048,596		21,492	11,089	9
10	18	Directors Fees	Days	2,032,280		141,444		21,365	1,487	10
11	20	Public Relations	Days	2,032,280		69,706		23,907	820	11
12	33	Taxes	Days	2,032,280		294,202		21,442	3,104	12
13	19	Professional Services	Days	2,032,280		2,535,843		22,241	27,752	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 21,636,111	$ 14,483,187		$ 256,727	25

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2	NOT APPLICABLE											2
3												3
4												4
5												5
	Working Capital											
6												6
7	NOT APPLICABLE											7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11	NOT APPLICABLE											11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Roosevelt Square-Murphysboro **#** 0040808 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 88,075	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 77,764	2
3. Under or (over) accrual (line 2 minus line 1).		$ (10,311)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 40,514	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 30,203	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999	38,431	11
2000	39,333	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Roosevelt Square-Murphysboro COUNTY Jackson

FACILITY IDPH LICENSE NUMBER 0040808

CONTACT PERSON REGARDING THIS REPORT Rebecca Schrader

TELEPHONE (502) 394-2100 FAX #: (502) 394-2353

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-09-176-001-0060	Land/Building @ 1501 Shoemaker	$ 39,332.66	$ 39,332.66
2.		Drive Murphysboro, IL	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 39,332.66	$ 39,332.66

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 15,366 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	4.06 Acres	1995	$ 8,000	1
2					2
3	TOTALS	4.06 Acres		$ 8,000	3

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	76		1995	1972	$ 534,601	$ 21,384	25	$ 21,384	$	$ 140,778	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Roof			1995	3,300	330	10	330		2,118	9
10	Storage Shed			1995	1,301	130	10	130		813	10
11	20% Down Roof			1995	5,100	510	10	510		3,060	11
12	Roof			1996	20,444	2,044	10	2,044		11,926	12
13	Vinyl Flooring			1996	1,282	128	10	128		737	13
14	Laundry Room Modication			1996	4,223	422	10	422		2,428	14
15	Laundry Room Modication			1996	3,450	345	10	345		1,926	15
16	Water Heater			1998	532	106	5	106		319	16
17	3 Ton Heater			1999	3,800	380	10	380		855	17
18	Wire Shelves			1997	532	53	10	53		257	18
19	Bathroom			1997	4,312	431	10	431		2,012	19
20	Rewire Building Receptacles			1998	1,000	100	10	100		392	20
21	Smoke Detector			1998	1,595	160	10	160		611	21
22	Showers			1998	7,900	790	10	790		2,897	22
23	Central Air			1998	6,889	689	10	689		2,411	23
24	Building Remodel			1999	7,355	736	10	736		2,023	24
25	Heating/Cooling Unit			1999	2,354	235	10	235		628	25
26	Electrical System Upgrade			1999	109,090	10,909	10	10,909		29,091	26
27	Furnace			2000	2,795	280	10	280		326	27
28	Ceiling Section			2001	1,754	132	10	132		132	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 723,609	$ 40,294		$ 40,294	$	$ 205,740	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 66,030	$ 13,766	$ 13,766	$	5	$ 43,817	71
72	Current Year Purchases	3,756	472	472		5	472	72
73	Fully Depreciated Assets	73,005					73,005	73
74	Corporate Allocation		9,349	9,349		5	9,349	74
75	TOTALS	$ 142,791	$ 23,587	$ 23,587	$		$ 126,643	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 874,400	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 63,881	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 63,881	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 332,383	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - Building Owned

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 14,473 Description: Copier $1,937; Postage $619; Diswasher $828; Corporate Allocation $11,089
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2000 Ford E-350	$ 785.42	$ 9,425	17
18			Payment varies		18
19			due to depreciation		19
20			expense		20
21	TOTAL		$ 785.42	$ 9,425	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 131

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)		12,647		12,647
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$ 12,647	$	$ 12,647
10	SUM OF line 9, col. 1 and 2	(e)	$ 12,647			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	767,056		3
4	Supply Inventory (priced at)	19,104		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	9,216		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): I/C Receivable	806,623		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,601,999	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	8,000		13
14	Buildings, at Historical Cost	534,601		14
15	Leasehold Improvements, at Historical Cost	189,008		15
16	Equipment, at Historical Cost	142,791		16
17	Accumulated Depreciation (book methods)	(323,033)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deposits	2,298		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 553,665	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,155,664	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 323,311	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	47,105		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,183		31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,561		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 420,160	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	(93,334)		42
	Other Long-Term Liabilities(specify):			
43	I/C Payables	213,356		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 120,022	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 540,182	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,615,482	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,155,664	$	48

***(See instructions.)**

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,391,536	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,391,536	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	223,946	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 223,946	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,615,482	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,609,005	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,609,005	3
	B. Ancillary Revenue		
4	Day Care	729,097	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 729,097	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	27,256	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	46	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 27,302	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,365,405	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	478,687	31
32	Health Care	1,980,684	32
33	General Administration	411,321	33
	B. Capital Expense		
34	Ownership	116,785	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	153,982	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,141,459	40
41	**Income before Income Taxes (line 30 minus line 40)****	223,946	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 223,946	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,849	2,021	$ 38,637	$ 19.12	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	5,838	6,454	82,058	12.71	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	1,575	1,575	12,647	8.03	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,213	2,424	26,845	11.07	10
11	Social Service Workers	1,862	2,098	29,322	13.98	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	10,257	11,492	82,484	7.18	15
16	Dishwashers					16
17	Maintenance Workers	1,416	1,727	16,561	9.59	17
18	Housekeepers	6,871	7,797	54,819	7.03	18
19	Laundry	8,821	9,591	70,497	7.35	19
20	Administrator	2,030	2,124	55,186	25.98	20
21	Assistant Administrator					21
22	Other Administrative	3,868	4,128	42,660	10.33	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	9,668	10,479	129,354	12.34	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	71,349	78,152	660,631	8.45	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	127,617	140,062	$ 1,301,701 *	$ 9.29	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	169	$ 5,898	1-3	35
36	Medical Director	480	19,200	9-3	36
37	Medical Records Consultant	24	1,188	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	85	2,130	10-3	39
40	Physical Therapy Consultant	81	4,050	10A-3	40
41	Occupational Therapy Consultant	76	5,675	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	125	7,367	10A-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Laboratory	9	216	10-3	46
47	Dental	70	1,836	10-3	47
48	Psychology	70	5,073	10A-3	48
49	TOTAL (lines 35 - 48)	1,188	$ 52,632		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	5,647	151,050	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	5,647	$ 151,050		53

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Greg Heck	Administrator	0	$ 55,186
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 55,186

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ADP	Payroll Processing	$ 5,919
Clyde Jackson - HR	Affirmative Action	612
Nonallowable Expenses		584
Amount to Reclassify to other lines		8,507
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 15,622

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 36,949
Unemployment Compensation Insurance	
FICA Taxes	98,214
Employee Health Insurance	57,118
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Unemployment Taxes	16,374
Life Insurance	1,208
LTD/LOT Benefits	2,260
Pension Benefits	7,210
Employee Inoculation	1,458
Tuition Reimb Benefits	398
Corporate Overhead	13,271
TOTAL (agree to Schedule V, line 22, col.8)	$ 234,461

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,014
Health Care Worker Background Check	
(Indicate # of checks performed)	6,701
Dues & Subscriptions	8,783
Corporate Overhead	820
	200
	50
Less: Public Relations Expense	(820)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,748

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,287
Out-of-State Meals	194
Out-of-State Lodging	2,506
In-State Travel	961
In-State Meals	267
In-State Lodging	377
In-State Rental	66
Seminar Expense	741
Corp Overhead	6,217
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,616

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4	NOT APPLICABLE												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **NONE**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **NONE** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **46**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **YES**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **KPMG Peat Marwick** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Roosevelt Square, Operation #374, Location # 57002
Schedule V, Line 24: Travel and Seminar Expense, Page 3
Illinois ICF Cost Report
For the Twelve Months Ended 12/31/01
Out of State Travel

Vendor/Employee	Reason For Travel	Destination	Mileage	Lodging	Meals	Rental	Registration	Airfare	Total Expenses	Month	Mileage	Mileage Rate	Mileage Reimb
Genetta Jones	Individual Service Coordinator Training	Indianapolis	201.5	0	0	0	0	0	201.50	January	620	0.325	$ 201.50
Genetta Jones	ISP Training/Indianapolis IN	Indianapolis	276.26	89.76	0	0	0	0	366.02	January	850	0.325	$ 276.25
Gregory Heck	Oracle Training/Louisvile, KY	Louisville	153.72	179.53	7.49	0	0	148	488.74	January	473	0.325	$ 153.73
Bill Durham	Oracle Training/Louisville, KY	Louisville	84.99	0	18.53	0	0	0	103.52	January	523	0.325	$ 169.98
Gregory Heck	Admin Orientation/Louisville, KY	Louisville	159.24	388.39	21.95	148.82	0	0	718.40	February	490	0.325	$ 159.25
Bil Durham	Food Show/ St. Louis	St Louis	148.36	0	9.35	0	35	0	192.71	April	430	0.345	$ 148.35
Gregory Heck	HR Mgr Training/ Terre Haute IN	Terre Haute	0	0	0	80.85	0	0	80.85	April	*	*	*
Gregory Heck	Regional Admin Training/ Lawrenceburg, II	Lawrenceburg, IN	0	264	14.5	0	0	0	278.50	April	*	*	*
Gregory Heck	Regional Admin Mtg/French Lick	French Lick	134	292.44	7.94	0	0	0	434.38	August	390	0.345	$ 134.55
M. Morrison & V. Morton	Hrizon Training/ Louisville, KY	Louisville	407.86	697.77	92.36	0	0	0	1,197.99	September	1182	0.345	$ 407.79
Gregory Heck	Budget Trng/Indianapolis, IN	Indianapolis	193.2	87.69	22.17				303.06	October	560	0.345	$ 193.20
Gregory Heck	Administrator Mtg/ Louisville, KY	Louisville	150.76	506.32					657.08	December	450	0.335	$ 150.75
			1,909.89	2,505.90	194.29	229.67	35.00	148.00	5,022.75				

Mileage	1,909.89
Lodging	2,505.90
Meals	194.29
Rental	229.67
Seminars	35.00
Airfare Travel	148.00
	5,022.75